TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Health Fort Worth

Respondent Name
XL Insurance America Inc

MFDR Tracking Number
M4-18-0064-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 6, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim was originally submitted on 12/02/2016. A notification advised the claim was received and accepted by Corvel."

Amount in Dispute: $1,044.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CorVel maintains the requestor, Texas Health Fort Worth is not entitled to reimbursement for date(s) of service 09/0816 to 09/28/16 in the amount of $1044.68 based on failure to timely submit a complete medical bill in accordance with the Texas Workers' Compensation Act and Division rules."

Response Submitted by: CorVel Healthcare Corporation

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
September 8 – 28, 2016	Physical Therapy Services	$1,044.68	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.
3. 28 Texas Administrative Code §102.4 establishes rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.
5. Texas Labor Code §408.0272 provides certain exceptions for untimely submission of a medical bill.
6. 28 Texas Administrative Code §134.403 sets out the fee guidelines for outpatient hospital services.
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – The time limit for filing has expired.

- W3 – Appeal/Reconsideration
- B13 – Payment for service may have been previously paid
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- P12 – Workers' Compensation State Fee Schedule Adj
- R88 CCI: Mutually Exclusive Procedures
- 231 – MUE procedures cannot be done in same day

Issues

1. What is the timely filing deadline applicable to the medical bills for the disputed services?
2. Is the carrier's denial of Code 97530 GP PO supported?

Findings

1. The requestor is seeking reimbursement for physical therapy services in the amount of $1,044.68 for dates of service September 8 – 28, 2016. The insurance carrier denied the disputed services with claim adjustment reason codes: 29 – "The time limit for filing has expired."

   The requestor states, "This claim was originally submitted on 12/02/2016. A notification advised the claim was received and accepted by CorVel."

   28 Texas Administrative Code §133.20(b) requires that, except as provided in Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided."

   Texas Labor Code §408.0272(b) provides certain exceptions to the 95-day time limit for bill submission:

   > Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if:
   > (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with:
   > (A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured;
   > (B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or
   > (C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title; or
   > (2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider.

   None of the exceptions found in Section 408.027(a) of the labor code were found. For that reason, the health care provider was required to submit the medical bill not later than the 95th day following the date the disputed services were provided.

   28 Texas Administrative Code §102.4 (h) states,

   > Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on:
   >
   > (1) the date received, if sent by fax, personal delivery or electronic transmission or,
   >
   > (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday.

Review of the submitted documentation found nothing to support the requestor's statement, "…notification advised the claim was received and accepted by Corvel." Therefore, the carrier's denial is supported. No additional payment is recommended for dates of service September 8, 2016 through September 14, 2016.

2. The carrier denied Code 97530 GP PO for dates of service September 19, 26 and 28, 2016 as R88 – "CCI: Mutually Exclusive Procedures" and 231 – "MUE procedure cannot be done in same day."

   28 Texas Administrative Code 134.403(3) and (d) states in pertinent part,

   > "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.
   >
   > For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided

   Review of the National Correct Coding Initiatives (CCI) found at www.cms.gov/Medicare/Coding/, finds "Per CCI guidelines, procedure code 97530 has a CCI conflict with Procedure Code 97140." Based on this review, the Division finds the carrier's denial of code 97530 is supported. No additional payment recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		October 5, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.